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INFORMATION…..community options program

from the Bureau of Aging and Long Term Care Resources

An "At-A-Glance" Summary of Most of 2004 Financial Eligibility / Rates in Long Term Support

The purpose of this bulletin is to provide care managers and others with an "at-a-glance" review of rates and financial standards for 2004 in various long term support programs. All of the information presented here is published in separate, individual memos from a variety of sources in the Division of Disability and Elder Services and the Division of Health Care Finance; the source document should be reviewed for detail.

I. Medicaid Home and Community Based Services Waiver.

Medicaid Waivers are a source of funding for long term support services for persons who are otherwise eligible for Medicaid funded institutional care. Waiver funding enables the arrangement of comprehensive services for persons living in the community. Community Integration Programs 1A and 1B serve persons with developmental disabilities. Community Integration Program II (CIP II) and Community Options Waiver Program (COP-W) serve persons who are elderly or have a physical disability.

A. The State Maximum Per Diem Average for Community Integration Program II (CIP II) and Community Options Program-W (COP-W) is $41.86/day.

- Counties are reimbursed fully for expenses for each CIP II participant up to an average of $41.86/day.
- For COP-W the state match is available to counties as an annual fixed allocation. Counties may spend an average of $41.86/day for COP-W, but slots are not budgeted at that rate. The per diem and number of individuals served in COP-W is limited by the allocation or the availability of additional local match.

B. Community Integration Programs 1 A/B, CSLA and Brain Injury Waiver Federal Per Diem Rates for Current and New Slots.

The following chart lists the "state matched Medicaid per diem[1]"

[1] "State matched per diem" refers to the amount of funding earned by a county for each day a CIP 1A,

associated with each different type of CIP 1 A/B and BIW slot. It also provides information on both the federal and local Medicaid matching percentage rates. Both of these rates will be applied to claims for all allowed service and administrative costs which are on average above the state Medicaid per diem. The federal Medicaid matching percentage is used to determine the amount of additional federal funding the county will receive to reimburse their costs above the matched per diem. The local Medicaid matching percentage is used to determine the amount of local matching funds needed to qualify for these additional federal funds.

Community Integration Programs 1 A/B and Brain Injury Waiver
Federal Per Diem Rates for Current and New Slots

2004 Rates	CIP 1A Regular Slots			CIP 1B Regular Slots	CIP 1B Locally Matched Slots	CSLA Slots (no longer available as of 1/1/2004)	Brain Injury Waiver All Slots	Brain Injury Waiver Local Match
	Per Diems	From:	To:	As of 7/01/02			As of 7/1/02	As of 7/1/02
Slot per diem amt. Reimbursed by matched Medicaid funds: Jan/Dec. 2002	$125.00 $153.00 $184.00 $190.00 $200.00 $225.00 $325.00	**Prior to** 7/1/95 7/1/97 7/1/00 7/1/01 7/1/02 7/1/03	7/1/95 6/30/97 6/30/00 6/30/01 6/30/02 6/30/03	$49.67	0	0	$180.00	0
% of ALL costs* above amt. on row one partially paid by federal share of Medicaid	59.90%	59.90%	59.90%	59.90%	59.90%	59.90%	59.90%	59.90%
% of ALL costs* above amt. on row one partially paid by local funds	40.10%	40.10%	40.10%	40.10%	40.10%	40.10%	40.10%	40.10%

* State/federal percentages are subject to change per notification from Centers for Medicare and Medicaid Services.

C. Brain Injury Waiver (BIW)

Beginning January 1, 1995, Medicaid eligible persons who meet the definition of brain injury as a developmental disability under s.51.01 (2g). Stats., and who are receiving or are eligible for post acute rehabilitation institutional care may receive community services in this Medicaid Waiver.

CIP 1B or Brain Injury Waiver slot is actually in use by an eligible participant. These Medicaid dollars are composed of federal Medicaid funds and state general purpose revenues used as match and include no local matching funds.

D. Medicaid Waiver Income, Asset and Cost-sharing Amounts

To be eligible for a Medicaid Waiver, each individual must meet income and asset tests. Eligible persons are protected by spousal impoverishment legislation. Once a person begins participating in a Medicaid Waiver program, a certain amount of income is protected in order to pay for room, board and personal expenses (personal maintenance allowance). Certain additional deductions from income apply (e.g., health insurance premium, specified court ordered expenses), and remaining funds are subject to cost-sharing. The following limits apply to all Medicaid Waivers: Community Options Program-W, Community Integration Programs II, 1A and 1B and Brain Injury Waiver.

2004 Medicaid Waivers Monthly Income Limits	Asset Limits
Group A - Eligible for "regular" Medicaid, or Group B - Eligible under a special income limit of up to **$1,692** Group C – Medically Needy (Income above $1,692 but incurs enough medically related expenses to reduce income to the medically needy income limit ($591.67) Spousal Impoverishment Income and Asset Protections Apply as explained below.	• $ 2,000 for a "single"* individual • See below for spousal Impoverishment Protections

* Single means: unmarried, legally separated or, under spousal impoverishment, having been on the program for 12 months or more.

2004 Spousal Asset Protection Amounts:

If couple combined assets are:	At-home (community)spouse may keep:
$0 - $50,000	ALL
$50,001 - $100,000	$50,000
$100,001 - $185,520	HALF of the combined assets
Over $185,520	$92,760

Spousal Impoverishment Asset Protections Apply As Follows:

Applicant / Participant	Applicant/Participant's Spouse	Do spousal impoverishment rules apply?
Residing in a medical institution for 30 or more days	In community	YES
Residing in a medical institution for 30 or more days	Residing in a medical institution for 30 or more days	NO
Residing in a medical institution for 30 or more days	Participating in a community waiver program	YES
Participating in a community waiver program	In community	YES
Participating in a community waiver program	Residing in a medical institution for 30 or more days	NO
Participating in a community waiver program	Participating in a community waiver program	YES

Note: When both spouses are on waivers, after each spouse has been a waiver participant for 12 months and s/he continues to be a waiver participant, s/he is considered to be "single" and must have no more than $2,000 in countable assets to remain eligible for community waivers.

2004 Spousal Impoverishment Income Protections

Minimum Monthly Spousal Income Allocation	$2,020.00*
Maximum Monthly Spousal Income Allocation	$2,319.00
Maximum Monthly Family Member Income Allocation	$505.00*

- Amount changes around March of each year

2004 Cost-Sharing Amounts

Minimum Personal Maintenance Allowance	$744.00
Maximum Personal Maintenance Allowance	$1,692.00

II. Regular Community Options Program Financial Eligibility

Six Month Resource Allowance:

Each adult applicant/participant:	$30,890.00
Each child applicant/participant:	$93,258.00

Monthly Income Allowance for "Resident's" Spouse:
(Applicant/participant is a resident of an adult family home, CBRF, nursing home, or other institution)

Spouse is a community spouse	$ 2,319.00
Spouse is also on COP or on Medicaid Waivers	$ 1,508.00

Irrevocable Burial Trusts
Effective July 1, 2003, the amount of funds which may be kept in an irrevocable burial Trust was raised from $2,500 to $3,000.

III. Regular Community Options Program Service Expenditures

The "regular" Community Options Program is state-funded and is designed to divert or relocate individuals of all age/target groups from nursing homes.
For those counties whose average caseload costs may exceed the state share of nursing home cost of $1,395/month, a variance to the rate is usually possible because statewide average spending remains well below this allowable maximum.

Average Reimbursement Rate for Regular Community Options

1994	$880/month
1995	$965/month
1996	$974/month
1997	$998/month
1998	$1,043/month
1999	$1,056/month
2000	$1,147/month
2001	$1,095/month
2002	$1,253/month
2003	$1,256/month
2004	$1,395/month

IV. Limitations on Funding of Community Based Residential Facilities (CBRF's)

Several changes have occurred as a result of the 2001-2003 budget process and the implementation of provisions relating to facility sizes and conditions under which COP, COP-W and CIP-II can be used in CBRFs. All of these changes are detailed in DSL Memo Series 2002-02, released on April 5, 2002. A subsequent BALTCR memo dated

April 12, 2002 provides technical assistance on the five conditions for funding in CBRFs. In summary, these changes include:

- As of May 1, 2002, in order to use COP, COP-W or CIP-II funding in any size CBRF, the following **five conditions** must be met:
  - a pre-admission assessment or consultation has been conducted prior to admission to the facility, and
  - home-care has been determined infeasible, and
  - the facility provides quality care within a quality environment, and
  - the CBRF is preferred by the individual, and
  - the CBRF is cost effective compared to other options.

  As of January 1, 2003, counties that had not previously done pre-admission assessments or consultations for individuals going into over 20 bed facilities had to begin doing so to enable persons to be eligible for COP or COP-W/CIP II funding in the future.

  Persons entering CBRFs that consist entirely of independent apartments and facilities with dementia programming for an individual with Alzheimer's disease or another dementia, subject to size limitations, are not required to meet any of the five conditions.

- COP-Regular, COP-W, and CIP-II funding may now be used in CBRFs with up to twenty beds. No variance is required for the use of these funds in CBRFs with up to twenty beds, however the above five conditions must be met.

- Use of these funds in CBRFs with over twenty beds requires DHFS approval. For CBRFs with more than twenty beds, a facility specific variance – approved by the local Long Term Support Planning Committee - must be sought by a county agency and granted by the Department. DSL Memo 2002-25 (issued January 2, 2003) and COP Informational Bulletin # 164 (issued September 25, 2003) provide updated information on using over 20 bed facilities. Facilities with more than twenty beds that consist entirely of independent apartments do not require a variance.

V. Residential Care Apartment Complexes

State statutes limit the amount of waiver funds that can be spent on supportive, personal and nursing services provided to an individual residing in a state certified RCAC to an amount not to exceed 85 percent of the statewide average daily cost of Medicaid reimbursement for nursing home care. This amount has been redetermined to be $77.81 per day effective January 1, 2004 (from $73.50 in 2003). This is not a rate for RCACs, but a ceiling on the amount of waiver funding that can be reimbursed for services in a RCAC. COP is not an allowable funding source for RCACs.

VI. Supplemental Security Income (SSI) Payment Levels for 2004

SSI is a national program of monthly cash payments for people who are elderly or have a disability and who have limited income and assets. It consists of a basic federally-funded payment level with a state-funded and state-determined supplement.

The new SSI payment levels listed below are effective January 1, 2004 through December 31, 2004. The 2004 federal SSI benefit rates reflect a cost of living adjustment increase. The state supplement to the federal SSI has remained the same since 1998. The asset limit remains unchanged at $2,000 for an individual and $3,000 for a couple.

The state has contracted with EDS to implement the state administration of the state supplement. Other than those in a work incentive program or those grandfathered in 1995, a person must be eligible for some federal benefit in order to receive the state supplement.

SSI Payment Rates Effective **January 1, 2004**

Living Arrangement	Federal Benefit	State Supplement	Total Payment
A. Own Household			
INDIVIDUAL	$564.00	$ 83.78	$647.78
COUPLE	$846.00	$132.05	$978.05
B. Household of Another			
INDIVIDUAL	$376.00	$ 83.78	$459.78
COUPLE	$564.00	$132.05	$696.05
C. Own Household with Ineligible Spouse			
INDIVIDUAL	$564.00	$130.43	$694.43
D. Household of Another with Ineligible Spouse			
INDIVIDUAL	$376.00	$135.05	$511.05
E. Exceptional Expense Supplement			
INDIVIDUAL	$564.00	$179.77	$ 743.77
COUPLE	$846.00	$477.41	$1,323.41
F. SSI Caretaker Supplement Effective November 1, 1999	$250 for the first eligible child and $150 for each additional eligible child		

Source: State SSI Coordinator, Division of Disability and Elder Services

SSI, "Own Household," (A above), includes individuals who live alone as well as individuals who live with others but pay their proportionate share of food, shelter and utility costs. SSI, "Household of Another," (B above), includes only those individuals or couples living with others and receiving in-kind support, i.e., not paying their proportionate share of household expenses. The Social Security Administration reduces the federal benefit by one third in lieu of calculating the actual value of in-kind support received. SSI, "Ineligible Spouse," (C above), means that one member of a couple is aged, blind, or disabled and the other member is not any of these.

The SSI-"E" supplement is available to SSI recipients who need at least 40 hours a month of assistance with activities of daily living and are certified by county agencies or their designees. Effective July 1, 2000, in addition to individuals who live in their own homes or the home of another, SSI individuals who reside in the following community settings may be eligible for this supplement:

- DHFS certified Residential Care Apartment Complexes (RCACs)
- Community Based Residential Facilities (CBRFs) certified as consisting entirely of independent apartments, regardless of size, and
- Effective July 1, 2002, in CBRFs with up to twenty beds.
- Adult Family Homes either licensed by DHFS or certified by county agencies.

VII. Caretaker Supplement

Payments for this supplement – which is paid with the State SSI check to SSI eligible caretaker parents – is $250 for the first child and $150 for each additional child. Eligibility for this supplement is determined as part of the Medicaid eligibility process for the qualified children at county human and social services agencies. More information is available by contacting the county agency or by calling the SSI Helpline at 1-800-675-0249.

VIII. Katie Beckett Program

The Katie Beckett Program is a Medicaid subprogram for certain children who have long term disabilities or complex medical needs and who live at home with their families. Unlike regular Medicaid, where a portion of parental income and assets are considered to be available to the child for eligibility purposes, under the Katie Beckett Program parental income and assets are disregarded. Only the child's income and assets are considered, and these cannot exceed the standards for a person in an institution. The income standard is indexed to three times the federal payment rate for an individual on SSI.

Katie Beckett Child's Maximum Monthly Income Limit	$1,692.00
Katie Beckett Child's Maximum Asset Limits	$2,000.00

IX. Medicaid Rates for Personal Care, Home Health Agency, Private Duty Nursing and Respiratory Care

The updated Medicaid Maximum Allowable fees for personal care, home health agencies and private duty nursing may be found at: www.dhfs.state.wi.us/medicaid3/maxfees/pdfs/home-health-fees.pdf.

A copy of the document is attached. Rates may change. Consult web site for most updated information.

X. Medicaid Reimbursement Rates for Prescription Drugs

Medicaid reimbursement rates for prescription drugs is as follows:

1. For *brand name* drugs (non-generic), reimbursement is average wholesale price (AWP) minus 12% discount. AWP of products is not determined by nor published by Medicaid. It is an extensive national listing updated twice a month, and published by First Data Bank. Medicaid loads the information into their data base, and pays the price minus the discount. Pharmacists receive the AWP listings. Effective July 1, 2004, the reimbursement rate changes to AWP minus 13%. For care managers who process Group C waiver participants, the simplest way to identify Medicaid reimbursement for brand name drugs would be to ask a pharmacy to look up the AWP for a particular drug and then deduct the current discount.
2. Most *generic* drugs are on the Maximum Allowed Cost (MAC) list published as attachments to the Medicaid pharmacy handbook and can be found at: www.dhfs.state.wi.us/medicaid2/handbooks/pharmacy/data_tables/datamainframe.htm. **(*Note that this list is updated monthly.*)**

XI. Medicaid Co-payments

Individuals who are new to the Medicaid program are informed about Medicaid co-payments during the application process. Care managers may also want to remind new clients about the existence of Medicaid co-payments. Co-payments range from $0.50 to $3.00 and are based on the cost of the service received. Certain services are exempt from co-payment (e.g., emergency services, services provided to nursing home residents, etc.). Information regarding Medicaid co-payments can be found under "**Updates"** at: www.dhfs.state.wi.us/medicaid1/recpubs/recppub.htm.

If you have questions about Medicaid Updates and/or the Medicaid Maximum Fee Schedule, contact Medicaid correspondence: 1-800-362-3002 or (local) (608) 221-5720; or contact Melanie Foxcroft, policy analyst for the Bureau of Aging and Long Term Care Resources, via e-mail: foxcrma@dhfs.state.wi.us or Ralph Pelkey, Assistive Technology Specialist for the Bureau of Aging and Long Term Care Resources, via e-mail: pelkerj@dhfs.state.wi.us or phone: 608/267-9091.

XII. Medicare 2004 Updates

<u>Part A Premiums</u>

- $343/month for individuals with less than 30 work quarters
- $189/month for individuals with 30 to 39 work quarters

<u>Part A Deductible</u>

- Inpatient hospital deductible is $876 per benefit period. A benefit period begins with the first day of hospitalization and ends when the patient has been out of the hospital or the skilled nursing facility for 60 days.

Medicare Part A Co-payments

- $219/day – Hospital stays from day 61 to day 90
- $438/day – Co-payment for Lifetime Reserve Days
- $109.50/day – Skilled Nursing Facility stays from day 21 to day 100

Part B Premium

- $66.60 per month

Part B Deductible

- $100.00 per year

Part B Co-insurance

- 20% of Medicare approved amount. For mental health treatment 50% of approved amount.

If you have questions about Medicare regarding participants who are 60 and older, contact your county's Elderly Benefit Specialist, located either in the County Aging Office or in the Human Services or Social Services Department.